MDR Tracking Number: M5-05-1727-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 02-18-05.

The IRO reviewed therapeutic exercises, neuromuscular re-education, office visits and manual therapy technique rendered from 06-18-04 through 10-14-04 that were denied based upon "V".

The IRO determined that the therapeutic exercises and neuromuscular re-education from 06-18-04 through 07-21-04 as well as the office visits on 07-02-04, 08-04-04, 09-03-04 and 10-05-04 **were** medically necessary. The IRO further determined that the remainder of the services in dispute **were not medically necessary.** The amount of reimbursement due from the carrier for the medical necessity issues equals **$1,753.76.**

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 03-11-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of CPT code 99213 date of service 07-07-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement recommended.

Review of CPT code 97110 dates of service 09-14-04 and 09-29-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. No reimbursement recommended.

CPT code 99080-73 date of service 09-03-04 denied with denial code "V" (unnecessary treatment with peer review). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction. Reimbursement is recommended in the amount of **$15.00.**

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees for dates of service 06-18-04 through 07-21-04 and 08-04-04 and 09-03-04 totaling $1,768.76 in acccordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Findings and Decision and Order are hereby issued this 25th day of April 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 31, 2005

To The Attention Of:

TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-1727-01
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Daily treatment notes
- Exercise sheets
- Designated Doctor Exam
- MRI report (2)
- EMG/NCV report
- TWCC forms
- X-ray report
- Functional capacity evaluation findings

Submitted by Respondent:

- Peer review report
- Independent Medical Exam report
- Explanation of benefits
- Denied services

Clinical History

According to the supplied documentation it appears that the claimant sustained an injury while lifting a child at work on ___. The claimant was seen at work in the Accident Clinic on 5/20/04 with Angela Upchurch, D.C. The claimant was removed from work and began chiropractic therapy. An X-ray of the lumbar spine was performed on 5/26/04 that revealed 7° left concavity mid-lumbar scoliosis. An MRI was performed on 7/14/04 that revealed no disc bulges or protrusions at any level. There were spondylotic changes with disc dehydration at the T8-9, T9-10 and T10-11 levels. An EMG/NCV study was performed on 8/13/04 and both were concluded as normal. A functional capacity evaluation was performed by Michael Arriens, II, D.C. on 10/15/04. It reported that the claimant was at a light job demand level. On 10/15/04 the claimant was seen by Steven A. Carter, M.D., for a Designated Doctor Evaluation. Dr. Carter felt the claimant was at MMI effectively 10/15/04 with a 5% whole person impairment rating. An Independent Medical Exam was done on 12/13/04 by James Hood, M.D. who reported the claimant suffered a lumbar sprain/strain and had a 0% impairment and would be able to return to work full duty, without restrictions. The documentation ends here.

Requested Service(s)

Therapeutic exercises (97110), neuromuscular re-education (97112), office visits (99213), and manual therapy technique (97140) for dates of service 6/18/04 to 10/14/04.

Decision

I agree with the treating physician and disagree with the carrier that the therapeutic exercises (97110) and neuromuscular re-education (97112) dated from 6/18/04 through 7/21/04 were medically necessary. I also agree with the medical provider that the office visits (99213) dated 7/2/04, 8/4/04, 9/3/04 and 10/5/04 were medically necessary.

I disagree with the treating provider and agree with the carrier that the remainder of services in question were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, maximum diagnosis in this case is a lumbar sprain/strain. The initial 8 weeks of passive and active modalities appear reasonable and medically necessary to treat the compensable injuries. This would include the dates of service through 7/21/04. At that time, it would be necessary to transition the claimant to a home exercise program as well as make the necessary referrals for other possible treatment options. This is consistent with allowing the provider to utilize a monthly evaluation code of 99213 to treat, diagnose and refer as medically necessary. Continued and ongoing therapeutic exercises and neuromuscular re-education beyond the initial 8 weeks is not seen as reasonable and medically necessary in the treatment of a lumbar strain/sprain.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 31st day of March 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder